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ABSTRACT

An evaluation attempted to demonstrate the effectiveness of an assessment, treatment, and counseling program for infants and mothers. The program was based on the importance of early identification and treatment of children's behavior disorders. The project was begun in 1968 at a center for disturbed preschool children. Intervention focused on the whole family, through a team approach including child, mother, caseworker, and therapist. Treatment included group discussions of family management and behavior problems and intensive counseling with mothers on an individual basis. Eighteen mother-child pairs were involved in the program. The evaluation consisted of (1) exploration of mothers' feelings about the program, and (2) an objective test and a clinical observation of each child. The investigation was of a descriptive nature and findings could not be analyzed statistically. (DP)

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AN EVALUATION OF A PILOT TREATMENT FOR INFANTS AND MOTHERS

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INTRODUCTION

The present pilot project was an attempt to demonstrate the effectiveness of an assessment, treatment, and counselling program for infants and mothers. It rested on the following assumptions:

1. Severe childhood disorders have a multiple causation in which constitutional factors play a dominent and predisposing role.
2. Danger signals of such disorders can be observed from birth on.[8]
3. Early diagnosis and treatment of symptoms help to prevent the formation of secondary behaviour problems resulting from parental feelings of guilt, inadequacy, and unrealistic expectations for the child and may enhance the chances of therapeutic success, although these symptoms often persist through life.

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4. Mal-adaptive behaviour at a later age can have its roots in early disturbance of mother-child relationship resulting from the child's initial state in interaction with his environment.[20]

The program developed out of a concern for the growing number of children who are brought to mental health services at an age when symptoms of their disturbances are already firmly rooted in their personality, and for those parents who so frequently tend to resemble the model of "parental perplexity".[3] It was found that these children require far longer and more costly treatment, yet show only modest therapeutic success.[4]

Several reasons can be postulated to explain a lack of emphasis on infancy as a period for assessment and treatment: (1) most clinicians only see children with full-blown problems, and thus may not be acquainted with early symptoms; (2) the recognition that individual differences in temperament exist from birth on[13] but do not necessarily lead to problems in later age; (3) parents may not have sufficient information to be able to evaluate their child's behaviour as atypical; (4) retrospective errors of mothers who, because of the emotionally laden content, are unable to give an accurate account of onset and quality of their child's disturbance; and (5) guilt feelings of parents who, believing to be the sole cause, deny as long as they can the child's behaviour.

Despite the above difficulties there is growing evidence in the literature in support of early intervention. For example, a follow-

up study of one hundred and thirty nursery school children with low adjustment ratings has shown that these children required the help of mental health services during later years.[22] Elonen[7] found that prognosis and therapeutic intervention is more successful the younger the child. Behaviour modification techniques are also more effective the earlier they are carried out.[2]

Clinical evidence was obtained from Dr. Haka-Ikse[11] at the Developmental Clinic at the Toronto Hospital for Sick Children. She notes that (1) symptoms of behaviour disorders can be recognized in children at a very early age, and that (2) much more can be done for children with problems if they are discovered and treated in the first few months of life.

Our own clinical experience concurs with the findings of others on the deep-reaching effect the child's disturbed and disturbing behaviour has on the total adjustment of his parents and other significant persons in his environment.[18] We have been impressed how explanation of causation by the psychiatrist in conjunction with casework and treatment for the child changed a parent's total attitude. Reduction of guilt mobilized a parent's ability to meet the child's needs realistically, and to look back at his developmental history in a less defensive and thus more accurate manner.

Perhaps another factor in favour of early assessment of both parents and child is the prevention of a behaviour disorder caused by the psychopathology of parents who select a certain child to be the object for the discharge of their own conflicts, projecting on the child "any characteristics the parents dislike in themselves

or in each other."[21]

Although problem causes of early childhood disorders can be stated on a theoretical level and earliest assessment and intervention can be defended in most cases, clinicians are still faced with the dilemma of deciding which of the behaviour is within normal limits, (resulting from individual differences[13]), which are deviant forms of adaptation, which are transient and which persisting disorders. Failing the evidence of a neurological examination, diagnosis can only be based on family history, the child's earliest developmental history, and on careful and often prolonged observation by a multi-discipline team. In this connection it should also be said that it has been our experience that a mother's intuitive feeling that her baby is "strange" should be taken seriously enough to lead to an investigation.

With the above considerations in mind, the pilot project was started during 1968 at the West End Creche - a treatment centre for emotionally disturbed preschool children. In keeping with our philosophy, the primary focus was on the total family. Full priority was given to a team approach which included the child, his mother, caseworker, and therapist. Sessions were divided between practical demonstrations and discussions of management problems with both the therapist and caseworker present, and intensive casework in individual sessions with the mother alone. Where it was considered necessary, home visits were made. The initial assessment was followed by a psychiatric interview with the parents,

and the diagnosis was given to them. Each child was reconferenced every three months. The length of treatment depended on the severity of the child's condition, an evaluation of the changes which occurred and which could resonably be attributed to therapy, and the mother's continuing willingness to remain involved in the program. In general, treatment varied from six to twenty-five months.

In keeping with the definition of a pilot project, it was felt necessary to evaluate the effectiveness of such a program through a follow-up assessment of the mother-child pairs. The aim of this paper is to present our preliminary findings.

Subjects

Eighteen mother-child pairs involved in the infant program at the West End Creche.

Description of Children

At the time of the initial contact, eleven children lived with their biological parents and seven were in foster homes. At the time of the follow-up, two of the foster children had been adopted, and two others were returned to their biological parents.

Table 1 shows the age when atypical behaviour was first noticed, and the age at which the child was first seen at the Creche, the type of behaviour which caused concern to the mother, and the I.Q. of the child during the initial assessment. Although the average age at which mothers became concerned was at eight months, the

average age when the children were seen by us was sixteen months. For some this meant a period of twenty months during which behaviour became more and more established, and parents increasingly perplexed.[3] A "wait and see" attitude seemed to be one of the causes, another, a lack of knowledge that psychiatric facilities for these very young children are available.

Method

The present investigation was carried out on two levels: (1) an exploration of the mother's feelings about the program, and (2) an objective test and a clinical observation of each child.

An optimum degree of uniformity was attempted by using the original team, and by keeping the procedure constant. The selection of test materials depended on the age of the child, and previous tests which had been administered elsewhere. The toys used in play sessions were those found in most nursery or kindergarten settings.

The casework interview consisted of a standard set of thirty-five fixed-alternative and open-ended questions, focusing on the mother's feelings at the time of the diagnosis, her assessment of the treatment process, etc. Initial information given by the mother to the psychiatrist was compared with her account given during the follow-up to measure her ability to recall, and the reliability of her reporting.

To provide a clearer overview, relevant data concerning each

child is presented in Table 2.

Results

The following factors inherent in the nature of this project prohibit statistical treatment of the data: (1) no control group was established; (2) some of the children had only recently terminated treatment; thus, the predictive value of the present assessment cannot be established with certainty; (3) variability of age at the time of treatment; (4) the number of subjects; and (5) variability of life experiences.

With the above reservations in mind, this investigation is of a descriptive nature, and all findings must be regarded as preliminary.

Attitudes of Mothers

The most significant factor which had a bearing on a mother's evaluation of the program appeared to be the nature of the diagnosis, and the implied seriousness of the child's condition. Thus, all but one of the mothers of the children diagnosed as autistic had serious reservations about the effectiveness of early treatment.

In contrast, mothers whose children's behaviour was caused either by environmental factors or by minimal brain dysfunction were unanimous in their support for the program, and strongly indicated the need for similar programs throughout the city. They appreciated the practical help given to them and the relief of

finding a place where they could talk, and where their problems were understood. They evaluated the project in terms of prevention of problems in school in later years, and most stated that they saw their child in a different light.

All but one mother who suffered from periodic bouts of severe depression appreciated the diagnosis given to them in a straightforward manner, although they remembered the initial "shattering" effect it had on the family. As can be expected, biological mothers were more seriously affected by the knowledge of their child's life-long condition, and required a longer period to adjust. In the long run, mothers reported that the truth helped them to have more realistic expectations of their child which resulted in less frequent upset for the child and parents. A measure of acceptance of early diagnosis followed by counselling, and treatment for the child, may be that in every case mothers followed the recommendations given by the psychiatrist not only during the time the child was in treatment but also following his discharge from the West End Creche.

Finally, two interesting observations could be made. While most mothers were able to recall the disturbed behaviour of their infant relatively accurately, we noticed a slight discrepancy in their reports to the psychiatrist and in those given to the caseworker. There appeared to have been a tendency in some to minimize present problems during the psychiatric interview, making the child appear "normal". In contrast, the caseworker was told about

the problems the child presented at home or at school. This type of denial may have been an unconscious reaction to the initial diagnosis, an effort to disprove its reliability.

Another finding resulted from examining the relationship of the age of the child when the atypical behaviour was first noticed with (1) the diagnostic category, (2) the child's position in the family, and (3) the sex of the child. None of these relationships appeared important. However, it was found that none of the mothers described the girls as manifesting hypoactive behaviour. It could be that hypoactive behaviour is much more acceptable as "normal" behaviour for girls than for boys.

Children

Table 2 describes the children at the time of the follow-up. Eleven of the children are at present enrolled in nursery schools, five of these remained in the Treatment Nursery Program at the West End Creche. Two children are in the public school system, three were referred to different treatment centres, and three are at home.

A comparison between the initial diagnosis and the follow-up diagnosis revealed that the only error was with regard to the primary or secondary causative factor. Where an initial diagnosis pointed to environmental factors associated with suspected minimal brain dysfunction, persistence and quality of symptoms indicated the latter to be the primary cause. Although two children were reported by mothers to have made a good adjustment, the problems re-

ported to the caseworker gave sufficient evidence for a borderline minimal brain dysfunction syndrome. One of the children whose seriously disturbed behaviour appeared to have been reinforced by the handling of an elderly and overly anxious foster mother was subsequently adopted, and made a normal adjustment in his new home. Despite improvement in some of the autistic children, residual symptoms were observed in all at the time of the follow-up, e.g., peculiar gait and voice quality, stereotyped movements, primitive modes of exploration, irrational fears, and fantasies.

In conclusion, it appeared that diagnostic categories can be reliable for children under the age of two.

An examination of the intelligence quotients provided some support for Pollack's[15] findings that "when behaviour disorder is associated with low intelligence there is a strong suspicion of organic pathology..." This seemed true for those infants who had been "untestable". Where the environment seemed to have been the primary factor, the I.Q. improved as the environment improved. Children who tested initially at an above average level, remained at that level, and in two instances improved despite a diagnosis of autism. This accords with Pollack's[16] thesis that "subsumed under this diagnosis is a wide variety of different subgroups that have little in common with one another." In general, it seemed that the initial formal test if combined with clinical observation[8] is sufficiently reliable and has predictive and diagnostic implications. This is not to say that in some cases a change in either direction may not occur at a later stage.

Summary

As previously mentioned, there are a number of children under the age of two who are suspected of having actual or potential problems but whose problems are not diagnosed. Few assessment and treatment programs for the very young child exist. The findings of the present exploratory study suggest the importance of such programs.

The value of early diagnosis was expressed by the majority of mothers despite its initial impact. It seemed that an informed mother is better able to understand her own attitude toward the child and can learn to cope with the problems of having a disturbed child.

We found mothers of infants to be a more reliable source of information concerning the child's earliest development than mothers whose children came into treatment at a later age. We attributed that to the fact that feelings of guilt and inadequacy had less time to activate defense mechanisms resulting in denial of early symptoms.

Although the present number of subjects was small, we were able to demonstrate the predictive power of early diagnostic signs and support the findings that the strength of a trait or combination of traits is predictive of its persistence.[13] Where serious behavioural dysfunctions were reported by parents, the diagnosis given in infancy remained unchanged. Where environmental factors were given as primary cause associated with brain dysfunction, evidence of the remaining symptoms reversed the diagnosis. In most cases the error was in favour of an organic brain syndrome.

An important aspect of the infant program was the close association between our clinical staff, foster mothers, and Children's Aid Societies. In consultation with our psychiatrist untimely moves of children had been prevented, or, if needed, more suitable specialized homes were found. Participation of foster mothers in the treatment program made it possible to discuss the handling of the child at an immediate and practical level and gave our staff a better understanding of the many-sided problems of child placement. The program structure at the West End Creche made it possible to integrate some of the children later in the preventive nursery program which provided continuation and stability for the child, and ongoing support for the foster family.

Working together with biological mothers of these infants brought our team closer to the deep-reaching and potentially detrimental effect of a disturbed child on his family. It reinforced our conviction of the urgent need for early assessment and therapeutic intervention.

While our data cannot demonstrate conclusively the value of early treatment, our findings tended to suggest that infants who manifest severe problems are not a product of their environment but of innately determined and persisting characteristics, who in later age, despite treatment or a changed environment, retain their original symptoms, albeit to a lesser or modified degree. This is not meant to be an indictment of earlier preventive treatment but a realistic appraisal of its long-term effectiveness.

In conclusion, may I be permitted for being as trite as to

say that where there is smoke there is usually also fire, and that it appears from our evaluation that it is possible to find the source of the fire, and to minimize the damage.

Implications

The preliminary findings of this pilot project bring to mind the following implications:

1. A need for the training of medical students in the field of early childhood disorders with special emphasis on recognition of diagnostic signs in children under the age of two. Such training must be based on a thorough knowledge of normal growth and development to enable the practitioner to differentiate indicators of a persistent disorder from passing problems of adaptation. A period of practicum in an appropriate treatment center should be a required part of any medical course.

2. A need for integrity and courage on the part of the pediatrician or general practitioner to inform a mother about her child's atypical behaviour, and to encourage her to have the child assessed at a mental health clinic without further delay.

3. The need for accurate and detailed records of the child's prenatal, perinatal, and postnatal history with special focus on individual differences which have been observed.

4. The debunking of the myth that a correct method of child rearing can solve all and every problem and will, in the end, produce the perfect child.

5. The need for an adequate number of community-based diagnostic and treatment facilities. Distance and a lengthy waiting list are often powerful deterrents for anxious and reluctant parents to seek help for their infant.

6. Willingness and open-mindedness on the part of the expert to take seriously the concerns of parents of these very young children.

7. And finally, the need for longitudinal studies of children diangosed and treated under the age of two.

Table 1

Age at Which Atypical Behaviour Was First Noticed

Age at Which Child Was First Seen at the West End Creche &

Behavioural Manifestations Which Led to Concern

Number	Sex	Age in months (when atypical behaviour was first noticed)	Age (when first seen at Creche)	Behaviour Manifestations	I.Q.
1	M	6	24	Hyperactive, sleeping problems, rejection of physical contact	-
2	F	18	21	Hyperactive, jealous	112
3	M	16	24	Hyperactive, eating problems, rejection of physical contact	average
4	M	6	7	Hypoactive, jerky, eye shifting,	100
5	F	0.5	21	Unresponsive	92
6	M	*	24	Hypoactive, withdrawn, temper tantrums, mannerisms	-
7	M	18	20	Clinging, delayed development	-
8	M	11	15	Hyperactive, clinging, crying spells, sensitivity to sounds, fearful of people.	90
9	M	14	20	Hyperactive, insistence on sameness, rejection of physical contact, clinging, fears, eye shifting.	115

Table 1 continued

10	F	0.5	21	Hyperactive, feeding problems, withdrawn	75
11	M	16	23	Hyperactive, sleeping & eating problems, rejection of physical contact, withdrawn, rocking, bouncing	73
12	F	9	14	Feeding problems, rigidity, vomiting, delayed development	114
13	M	0.5	15	Sleeping and feeding problems	-
14	F	11	20	Obsessions, withdrawals, eye shifting, regression, unduly upset when sick	112
15	F	12	16	Stubborn, delayed development	80
16	F	14	23	Hyperactive, sleeping & eating problems, intolerance to change, fears, hair pulling, eye rolling, clinging, delayed development	105
17	F	0.25	20	Odd (birth problem-depressed skills)	100
18	M	12	16	Self-destructive, temper tantrums	-

* Could not remember

Table 2

I.Q. and Diagnosis of Children When First Seen and Diagnosis at Follow-up

No.	First I.Q.	Original Diagnosis	Follow-up I.Q.	Follow-up Diagnosis
1	-	Environment	Above aver.*	Environment
2	aver.*	Environ.(delayed dev.)	112	M.B.D. (Environment)
3	aver.	Environment	average	M.B.D. (Environment)
4	100	Childhood Schizophrenia	Above aver.	Child. Schiz.
5	92	Organicity (retarded)	110	M.B.D.
6	-	Autistic features (environment)	94	Normal adjust.
7	-	Behaviour disorder (autism)	85	M.B.D. (Environment)
8	90	Minimal brain damage (retarded)	100	M.B.D. (slow)
9	115	Environment	115	Normal adjust.
10	75	Childhood Schizophrenia	Above aver.	Child. Schiz.
11	73	Childhood Schizophrenia	67	M.B.D. Autistic features
12	114	Childhood Schizophrenia	116	Child. Schiz.
13	106	Behaviour disorder (environment or organicity)	117	Environment (M.B.D.)
14	112	Environ.(organicity)	123	Normal adjust. (E)
15	80	Childhood Schizophrenia	80	Autism
16	105	Environment	89	Environ. (MBD)
17	-	Childhood Schizophrenia	100	M.B.D. (autistic features)
18	-	Childhood Schizophrenia	-	Child. Schiz.

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